COMPLEXITY IN CARING AND EMPATHY

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Michael Slote's *The Ethics of Care and Empathy* is a welcome addition to the growing literature on care ethics. Possibly its two greatest contributions are 1) connecting care ethics to the earlier tradition of moral sentimentalism[1] and 2) employing *empathy* in a way that extends care ethics into justice and global affairs.[2] In this brief and appreciative commentary, I will concentrate on *empathy* and ways in which Slote's work may add complexity to the analysis of caring.

Empathy

Slote and I have had conversations over the past few years about the use of *empathy*. We agree that the word is relatively new—first appearing in English at around the beginning of the 20th century. It entered the language through aesthetics, and there it was held to be an act of projection—projecting oneself into a work of art in order to understand it.[3]

Today it is widely acknowledged that empathy involves what earlier thinkers called *sympathy*, an attitude of "feeling with" another, and etymologically, this definition of sympathy is certainly correct. In contrast, even in some current philosophical literature, *empathy* retains a heavy cognitive connotation. Karsten Stueber, for example, accepts the early definition, writing:

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[1] Slote takes this project even further with his more recent *Moral Sentimentalism* (Oxford: Oxford University Press, 2010).

[2] Other care ethicists have contributed to the project of extending care ethics beyond the inner circle. See Virginia Held, *The Ethics of Care: Personal, Political, and Global* (Oxford: Oxford University Press, 2006); Nel Noddings, *Starting at Home: Caring and Social Policy* (Berkeley: University of California Press, 2002); and Noddings, *The Maternal Factor: Two Paths to Morality* (Berkeley: University of California Press, 2010).

[3] See Susan Verducci, "A Conceptual History of Empathy and a Question it Raises for Moral Education," *Educational Theory* 50(1): 63-80.

> Empathy as understood within the original philosophical context is best seen as a form of *inner or mental imitation for the purpose of gaining knowledge of other minds*.[4]

Unlike empathy, *sympathy,* as used by David Hume, is often held to be contagious. We may feel happy in the presence of others who are happy, fearful when others show fear, sad when others are sad. There is also an element of understanding in sympathy. When we understand what another is feeling or going through, we may feel the pain or joy of the other even though we know that our feeling is not identical to that other's and that in the same situation we might feel differently. Slote prefers to name this "feeling with" *empathy*, and in that he is joined by many social scientists concerned with affect. So long as we are careful, I think we can accept this comprehensive definition of empathy.

Different Vocabularies

I cannot undertake a history of care ethics here (although it is a task that needs doing), but we need to say something about the different vocabularies that appear in work on caring. Slote connects care ethics with earlier work in philosophy (Hume, Hutcheson, Adam Smith) and with current work in psychology, especially with that of Martin Hoffman.[5] Using recognized methods of philosophical analysis, he presents a convincing argument for the extension of care ethics into the concerns usually associated with justice and political liberalism. In contrast to others who write on care ethics, he rarely uses the words *relation, attachment, attention, reciprocity, responsibility, interdependence, mothering, needs,* or *motivational displacement*. This is not to say that Slote ignores these ideas, but he uses a different vocabulary to get at them, and these differences may open a whole world of further analysis for care ethicists.

Those of us who started writing on caring and care ethics in the 1980s located our work in various traditions. Carol Gilligan emphasized the "different voice" used by women in moral thinking. Virginia Held analyzed feminism in order to move toward a transformation of moral theory. I found a start in Martin Buber's relational ethics and, then,

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[4] Karsten R. Stueber, *Rediscovering Empathy* (Cambridge, MA: MIT press, 2006), p. 28.
[5] See Martin Hoffman, *Empathy and Moral Development: Implications for Caring and Justice* (New York: Cambridge University Press, 2000).

in women's experience in teaching and raising children. Sara Ruddick located the roots of caring in maternal thinking. Jean Watson started with the needs identified in nursing, and Kari Waerness pointed out the difference between caring and caregiving in social work.[6] As we grew stronger in our conviction that women's experience had something distinctive to offer, we depended more on one another than on traditional ethical frameworks.

Now we need to explore more deeply how the concepts identified in care theory work together. Consider, for example, the idea of "inductive discipline" that Slote (following Hoffman) emphasizes in his discussion of moral education. The idea here is that an adult encourages children to consider how others feel (to empathize) and to recognize when they bear some responsibility for the pain of others. Such acts of "induction" can be powerful. But almost certainly their power depends on the relationship already established between adult and child. If the child is *attached* to the adult—loves or admires her—the induction is likely to succeed. However, if the method is used as a mere technique by an adult unknown or disliked by the child, the result may well be a sulky concern for self, not empathy. Attachment may be a foundation for the learning of empathy.

We also have to be careful to encourage children to identify the needs expressed by others. Empathy should help us to recognize the hurt feelings and pains of others even if we have had no part in causing them. Moral sensitivity is not merely a matter of not causing pain, it should lead us to relieve pain whatever its cause.

In my own work, I have put emphasis on *attention.* Following Simone Weil and Iris Murdoch, I have described receptive attention as a fundamental characteristic of caring.[7] In *Caring*, I used the word *engrossment* to capture both the receptive attention required and the "feeling with" that accompanies such attention. Because *engrossment* was sometimes misconstrued as some sort of infatuation, I dropped the word and now use only *attention*.

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[6] See Carol Gilligan, *In a Different Voice* (Cambridge: Harvard University Press, 1982); Virginia Held, *Feminist Morality* (Chicago: University of Chicago Press, 1993); Nel Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1984); Sara Ruddick, *Maternal Thinking: Toward a Politics of Peace* (Boston: Beacon Press, 1989); Jean Watson, *Nursing: The Philosophy and Science of Caring* (Boulder: Colorado Associated University Press, 1979); and Kari Waerness, "The Rationality of Caring," *Economic and Industrial Democracy, and International Journal* 5 (2), 1984: 185-210.

[7] See Simone Weil, *Simone Weil Reader*, ed. George A. Panichas (Mt. Kisco, NY: Moyer Bell Limited, 1977) and Iris Murdoch, *The Sovereignty of Good* (London: Routledge and Kegan Paul, 1970).

But something has been lost in this change. The attention of which I speak is *receptive*; one-caring listens without the bias accompanying classroom forms of attention. A carer is truly open to the other, vulnerable to what she or he is feeling. This is not the kind of attention directed to some pre-established goal of our own. It is not the attention we direct to teachers when we are preparing for a test. I suspect that the philosophical temptation to simplify has infected both my work and Slote's. Moving from *engrossment* to *receptive attention* to *attention*, I must return to a fuller analysis of the attention that is so central to acts of caring. Similarly, I think Slote has perhaps packed too much into *empathy.*

Attention and Empathy

Although I did not use *empathy* in my earlier work, I spoke repeatedly of "feeling with" and being moved. If we use *empathy* to describe this experience, when and how does it occur? How does it connect with *attention*? In many, perhaps most, situations, we listen or observe receptively and then we feel empathy; that is, attention precedes empathy. As we listen to the other, we identify her feelings; we begin to understand what she is going through. As a result, we feel something. When what we feel is close to what the other is expressing, we may say that we are experiencing empathy. This experience leads to *motivational displacement*. We put aside our own goals and purposes temporarily in order to assist in satisfying the expressed needs of the other; our motive energy flows toward the purposes or needs of the other. This is the basic chain of events in caring.

However, it is not always this straight-forward. Sometimes what we hear from the other arouses feelings of alarm, disgust, or doubt. Our task then may be more complicated. We still feel for the other, but we may have to explain why his need cannot be satisfied; sometimes, we even have to convince him that, for the sake of others in the web of care, the need should *not* be satisfied. When we are actually repulsed by what we hear, we must ask whether we can preserve the caring relation without satisfying or even approving of the expressed need. In any case, even in moral disgust, a carer will not harm the cared-for and will try to move the relation in a healthier direction. My point in this paragraph is that what we feel as a result of our attention may not always be *empathy* as described by Slote. There is still a place for the original definition of empathy—an attempt to understand another's

mind. We do feel something as a result of the empathic experience, but we may not sympathize or "feel with" this other.

The situation might be even worse. Suppose we have several encounters with a person who has committed a harmful act—criminal assault, for example. If the person shows no remorse and suggests that the innocent victim "had it coming," we are unlikely to "feel with" that person. However, we may retain an inactive empathic attitude, and we will not permit deliberate pain to be inflicted on the criminal. In the language I have used, we remain "prepared to care," if the feelings expressed by the other—pain, fear, feelings of abandonment—are of the sort with which a carer can sympathize.

Slote's discussion of the deontological elements in care ethics is very helpful on issues of this type. Because we are committed to caring as a way of life, we accept at least one absolute: never deliberately inflict pain. Caring forbids torture and other inhumane acts. We are also prepared to move from the natural caring guided by inclination to the ethical caring that instructs us to meet and treat this other "as if" natural caring were active. Again there is a deontological element in the commitment to care that pushes us to employ ethical caring when natural caring fails.

Does attention always precede empathy? Surely there are times when a dramatic hurt occurs, and we automatically feel empathy; our attention is drawn to the one hurt. Our inclination is to relieve pain, save life, solicit help. Only the order has changed. Instead of attention, empathy, motivational displacement, response, we have empathy, attention, motivational displacement, response.

There is yet another possibility in what might be called the empathic circle. With some groups—our families, people who share important beliefs with us, people "like us"—we enter encounters in an empathic mode. We are ready to respond empathically. With other groups, we are not predisposed to exercise empathy; we may even resist actively. Here, if we are committed to care, attention is of primary importance. Often we suppose it is critical thinking that is involved here and, of course, it plays a definite role. But at what point? Even before the other has spoken? If we already know (or think we know) the other's mind, we can direct our attention to the words he uses and, analyzing them from our own perspective, confirm our initial opinions. We achieve what we take to be empathic

accuracy almost a priori. And, of course, we may be mistaken. We see this behavior repeatedly in political life.

But there is another approach to managing our attention. Iris Murdoch suggests that we might see justly or lovingly.[8] In the language of care ethics, this means to enter or re-enter encounters prepared to care, even if we are not initially predisposed to be empathic, to attend receptively. In the example used by Murdoch—that of M, a mother-in-law who is trying to see her daughter-in-law in a better light, M takes herself to task for being perhaps "old-fashioned…conventional…prejudiced and narrow-minded." M considers, "I may be snobbish. I am certainly jealous. Let me look again."[9] What might this tell us about empathic accuracy? It is not simply a matter of understanding the other in some entirely objective way. From the perspective of care ethics, it is a matter of seeing the other in the best possible light. It means examining our own frame of mind and how it influences our understanding. As remarked above, we usually do this almost automatically with close friends, family, and those with whom we agree on politics or religion. In the case of others—those initially outside our empathic circle—it requires a moral effort. It requires the application of *ethical* caring.

Slote and I are both interested in the problems associated with caring for people at a distance. We both argue, but somewhat differently, that –contrary to the demands of Peter Singer and Peter Unger—distance does matter.[10] Slote argues convincingly that distance matters because it affects our empathic response. I agree with this, but I also point to studies in evolutionary biology that confirm the human tendency to relate most closely and easily with those of similar genetic heritage.[11] I do not go to naturalistic extremes and argue that things *should* be as they *are*, but I do argue that any normative ethic that ignores "how things are" is unlikely to be taken seriously.

Because we are naturally disposed to respond empathically to those closest to us does not imply that we cannot learn to extend our empathy to strangers and distant others. If we are committed to care, we meet proximate strangers prepared to care; they address us

[8] Murdoch, *The Sovereignty of Good*, p.23.
[9] Ibid., p.17.
[10] See Slote, *The Ethics of Care and Empathy* (London and New York: Routledge, 2007), ch. 2.
[11] Noddings, *The Maternal Factor*.

directly, and we must respond. Singer (and others) would have us believe that the plight of a distant stranger puts exactly the same moral demand on us as that of the person right before us. (I should note that our empathy may be triggered at a distance if the object of our attention is someone already in our empathic circle—a son in the military, for example. I also argue that caring demands "completion," some response from the cared-for, and this is often absent in attempts to care for strangers at a distance.) Slote argues (rightly, I think) that the degree or strength of empathy is different. But there is more to consider. In care ethics, we speak of motivational displacement. When we attend and receive expressions of pain or need, we feel something akin to that pain (we empathize or sympathize), and then we experience motivational displacement; we are moved to help.

It is at this stage that the process of trying to care at a distance, sadly but inevitably, often breaks down. I may feel very bad about the victims of poverty or injustice in some far away land, but when I look at the pile of repeated solicitations from charitable organizations, local services, universities, and various groups dedicated to the welfare of animals, I have to conclude that I simply cannot respond (again) to all of them. I *feel* for the suffering, but an attempt at motivational displacement is hopeless. If I were religious, I might pray. Many do consider prayer a form of doing something. I might decide to vote only for people committed to global welfare, but I've already done this. I do not avert my gaze. I look right at the sufferers, but I admit that I can do nothing further. If, by a stretch, I can help one more sufferer, I must neglect the second one in line. As an individual, I quickly reach a position of helplessness. And, if the process goes far enough, I may suffer empathic exhaustion. For reasons of this sort, I have advised that we separate individual and collective responsibility. We have to work from an actual world and real possibilities.[12]

I thank Michael Slote for his work on these tough issues and especially for the incentive to study more deeply the connections among the central concepts and vocabularies of care ethics.

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[12] Ibid.